Proposal Cover Page

Name of Proposal: A Comprehensive Health Advancement Plan for Colorado

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Topic (a) Comprehensiveness

(1) What problem does this proposal address?

This proposal addresses the need for a health care system that makes affordable coverage for basic medical needs available to all residents of the state, without any connection to employment or to pre-existing conditions.

(2) What are the objectives of your proposal?

The objectives are:

(A) To make basic health care available to all Colorado residents

(B) To make health care portable, by cutting the link between employment and health care insurance

(C) To develop various programs to make the practice of medicine in this state more cost-efficient and cost-transparent, including training of providers

(D) To develop programs for citizen education on health care, together with incentives for reduction of risky life styles

Topic (b) General

(1) Please describe your proposal in detail.

Introduction.

This is a proposal for a modified single-payer health care system for the State of Colorado. It would provide comprehensive health care services to all residents of this state, while severing the connection between employment and health insurance. By replacing most private health insurance plans with a single-payer system, the plan would significantly lower overall state expenses for health care. The plan also allows market forces to act on a portion of the population who can afford co-payments.

Section I. Organization and Administration

1. Name. Legislation should create a new state agency-- the Comprehensive Health Advancement Program for Colorado, hereafter abbreviated

CHAPCO. Note: The word "advancement" is used, rather than "insurance," to emphasize the need for wide-ranging reform of the health care system, not just payment of bills.

2. Eligibility. The program should cover all residents of Colorado. Definition of "resident" is described under Topic d-3 (page 14). A system, such as a special card, for identifying persons covered by CHAPCO should be set up, but the use of Social Security numbers for identification would not be allowed.

3. Organization. An important feature of this proposal is a transition period of two years during which staff will work out organizational details of the full program prior to its activation in July of 2010. A comprehensive health care plan should not be imposed on an entire state by legislative fiat. A long and detailed planning period will be necessary. This is discussed more fully under Topic b-7 (page 12).

Establishment of a governing board, appointment of a CEO and Regional Directors are described under Topic b-5 (page 11). CHAPCO will need at least four departments: Financial Services, Public Health Education, Patient and Provider Relations, and Cost Containment. Financial Services, of course, will handle incoming funds and payments to providers. Incoming funds should go directly into the CHAPCO Trust, which should be administratively separate from the general fund for other state expenses (also see Topic l-1, page 22). The other three departments are described below.

4. Public Health Education. Long-term success of a universal health care system will depend on more public involvement in health care decisions than currently occurs. A Department of Public Health Education (DPHE) should be established within CHAPCO. The department should cooperate with similar agencies that already exist at the state, county and municipal levels, whenever it is appropriate to do so. CHAPCO programs might replace or absorb existing programs.

The Department of Public Health Education's goals should be (1) to increase public awareness of CHAPCO benefits and exclusions, and (2) to increase public awareness of ways for individuals to lead healthy life styles and avoid illness. Department personnel should actively contact churches and social organizations, offering classes on preventive health care. This program should emphasize education in rural

areas and in urban areas where low-income families tend to be concentrated. Over a period of several years, public health care education can save enormous amounts of money by reducing unhealthy behavior patterns that are associated with chronic diseases.

DPHE should also design a program of financial incentives that reward citizens for participating in preventive health care programs and improving their own health. The Department might, for example, offer a financial reward to persons who attend several educational sessions on preventive health care and then demonstrate an improvement in some quantifiable aspect of their health over a period of six months or longer. Possibilities might include a 20% reduction in weight for obese persons, a reduction of cholesterol level to a defined target, cessation of smoking or alcohol consumption (if some easily verifiable system for documenting such claims could be devised). The financial reward could be a reduction in co-payments (described in Topics e-2, page 15, and i-2, page 20) for the next year or a cash payment to patients who are below the income level at which co-payments are required.

Training programs to increase the supply of personnel in various health care fields that are inadequately represented now should be established. Examples would include family health care advocates, adult and children's mental health, and physicians' assistants. More effective use of health care non-physician professionals should reduce visits to physicians and hospitals significantly, thus making the entire system more cost-effective. A program to increase the supply of primary care physicians should also be established, using scholarships during the training years and long-term loans during the first years of setting up practices in rural or other underserved areas.

The Department of Public Health Education should also encourage Colorado citizens to develop a sense of ownership and participation in CHAPCO. One important step would be to increase the transparency of the system. This should include making the CHAPCO-approved fee schedule available to every Colorado resident. Another useful step would be to provide each patient with a statement for services rendered that contains a plain English description of the services and procedures for which CHAPCO is being billed for a given visit to a health care provider. This will help patients keep their own records (if they wish to do so) and it will also help them to decide whether providers have

made improper or inaccurate claims. Patients should have Internet access to their own medical records, including information on fees claimed by providers.

5. Ombudsmen. The Governing Board should establish a Department of Patient and Provider Relations within CHAPCO for the purpose of dealing with claims of inadequate or improper care by health care providers, claims of improper charges for services, and other types of dissatisfaction that may arise with patients. Providers who feel that compensation for services covered by CHAPCO is inadequate would also submit their grievances to the ombudsmen. Each regional office should have at least one staff member from the Department of Patient and Provider Relations whose primary duty is to deal with persons who have grievances against CHAPCO, and to mediate settlement of grievances without recourse to litigation whenever possible. If a major problem arises that may require a change in CHAPCO policies, the ombudsmen would probably be the first to recognize it. Ombudsmen should make formal reports to their regional directors on a regular basis.

The Department of Patient and Provider Relations should establish regulations for maximal protection of patient privacy, so that unauthorized persons cannot obtain access to a patient's records. The Governing Board should approve these regulations. All patients should have unlimited access to their own records, including electronic access.

There will also have to be an educational effort directed at providers, to help them adjust to the inescapable need to control costs. At present, many providers are unable to tell a patient how much a procedure will cost; so this must change. There is also an obvious need to reduce the number of tests physicians order as "defensive medicine," where they rule out highly unlikely possibilities without regard to the cost. This topic is intimately related to the need for limitations on malpractice awards, which should be a topic for separate legislation. During the two-year transitional period, CHAPCO staff should consult with providers, attorneys, and representatives of the public in order to make recommendations that the Governing Board would submit to the General Assembly for legislation to reform malpractice insurance, to limit claims against providers, or other appropriate regulations.

6. Cost Containment. The Governing Board should establish a Department of Cost Containment within CHAPCO, whose overall goal would be to make optimal use of CHAPCO funds in order to keep health care costs within acceptable limits.

(i) An important function of the Cost Containment department would be to decide what should be excluded from CHAPCO coverage without denying essential medical services to anyone. Some possibilities would be: limits on the frequency with which various laboratory procedures will be paid for by CHAPCO and paying only for generic varieties of prescription drugs, when the choice between generic and brand name varieties exists (and there is no known difference in efficacy). Limitations on the extent and level of long-term care would also be appropriate. In general, the Department of Cost Containment should continually evaluate potentially costly new procedures and instruments for their suitability to be covered by CHAPCO, bearing in mind the principle that the advance of technology will eventually make it impossible to offer every possible medical procedure to every patient.

(ii) The Department of Cost Containment should negotiate favorable prices from drug manufacturers via bulk purchases of prescription drugs and favorable prices via bulk purchases from suppliers of durable medical goods of those types that will be covered by CHAPCO. Note: This rule is not intended to make CHAPCO provide a warehouse for drugs and medical supplies. After a price agreement has been reached with a manufacturer, existing wholesalers would be able to order at the new price, which would then be passed on to retailers and then to consumers with customary markups. CHAPCO might have to regulate prices to the consumer if experience showed that retailers were using the new wholesale prices predominantly for their own advantage.

(iii) The Department of Cost Containment should be responsible for continuous evaluation of ways to make quality medical care available at reasonable cost, including ways to make efficient use of very expensive facilities such as MRI units. This might include paying for transportation to and from specialized facilities for rural patients, together with temporary housing for those patients if needed, rather than building new facilities in rural areas. Alternatively, if it can be clearly shown that there is redundancy of MRI units or other highly sophisticated equipment in some urban areas,

CHAPCO could subsidize transfer of some of that equipment to a rural area, along with funds for maintenance.

This program should continually try to identify aspects of health care where costs can be reduced without sacrificing quality. It is well known that health care in the United States costs approximately twice the per capita cost in most other technologically advanced nations. Private health insurance is generally recognized as an important element of higher United States costs, but it explains less than half the difference. A recent study by the McKinsey Global Institute [1] showed that US health care costs are relatively expensive at all levels, compared to other technologically advanced nations, even when adjusted for differences in GDP per capita. Anderson et al. [8] came to the same conclusion. There is room for significant improvement here, but the problem is complex.

(iv) The Department of Cost Containment should establish an ongoing program for optimal use of computer technology to maintain patients' records, with the long-term goal of establishing a comprehensive statewide database. As more effective procedures are developed, CHAPCO should make those procedures available to health care providers. Electronic availability of extensive data on each patient would be very helpful to providers in their clinical evaluations. As the electronic database grows, it will become a valuable resource for outcomes analysis, which will also impact clinical practice. An additional benefit of electronic records would be administrative savings, because a patients' family history, drug sensitivities, and other basic information would not have to be recorded separately by each provider. A computerized record of all claims made to CHAPCO would also be helpful in identifying either providers or patients who abuse the system.

Section II. Benefits.

1. Covered services. The Governing Board would have to define "basic health care services" and make that information freely available to the public at least six months before implementation of CHAPCO coverage in 2010. CHAPCO coverage should include outpatient care by primary providers and specialists, inpatient care in hospitals,

emergency care, some mental health services, basic vision and hearing care and correction, basic dental care, preventive health care, and prescription drugs. However, it may be necessary to exclude some health care services from coverage by CHAPCO, as part of the program for Cost Containment. Whether long-term care should be covered by CHAPCO is a difficult question. If it were freely available, there might be a large influx of people needing long-term care into the state. Another limitation might be on the duration of mental health services. Those decisions should be left to the discretion of the Governing Board after consultation with appropriate experts.

The Governing Board would have to develop a Fee Schedule for services to be provided by CHAPCO. This would have to be done during the transitional period, July 1, 2008-June 30, 2010. In addition to obtaining information and advice from CHAPCO staff, the Governing Board should also consult with organizations that represent most of the health care providers in Colorado. The savings made possible by adoption of a single-payer system would be taken into account in devising the new fee schedule, which should be adjusted so that providers, on average, neither benefit nor suffer financially from the new system. Establishing the fee schedule will require *negotiation,* not fiat. A large majority of Colorado health care providers would have to consent to the fee schedule or universal coverage would be impossible. Various fee schedules that could be starting points for creating a CHAPCO-specific fee schedule are available, of which the Medicare Physician Fee Schedule Database would probably be most useful. Fee schedule negotiations with provider organizations would have to be an ongoing process, with revisions being made every year or two.

It is also important for the public to have access to the CHAPCO Fee Schedule, so that those who wish to take an active role in managing their own health care costs can do so. Those fee schedules should include a brief English description of each item.

2. Medicare and Medicaid. It would be desirable for Medicare and Medicaid programs to be integrated with CHAPCO, but the General Assembly of Colorado cannot independently decide how this should be done. The CHAPCO Governing Board should be instructed to negotiate with the federal government for waivers that would allow transfer of Medicare and Medicaid payments into the CHAPCO Trust.

Both Medicare and Medicaid present problems. (A): If Medicare is incorporated into CHAPCO, will the 20% of a Medicare-approved fee that is the patient's responsibility be paid by CHAPCO? If Medicare fees are less than CHAPCO fees, will the federal government allow providers to bill Medicare for the CHAPCO-approved amount? (B): Medicaid is supported by contributions from the state and from the federal government (about 50%-50% in Colorado). If CHAPCO were to cover all residents of Colorado, it could be argued that Medicaid would become irrelevant, in which case Colorado might lose a substantial amount of federal money (more than a billion dollars). CHAPCO staff and/or legislators would have to figure out some way to prevent this from happening. If Medicaid were not incorporated into CHAPCO, would Medicaid patients be covered by CHAPCO for services not covered by Medicaid?

Solving these and related problems is one reason why a two-year transitional period between authorization and full activation of CHAPCO is necessary. If Medicaid and Medicare cannot be integrated into CHAPCO immediately, CHAPCO could still be activated for the other residents of Colorado, but it would be an undesirable situation, effectively defining Medicare and Medicaid patients as second class citizens in terms of health care. Non-inclusion of Medicare and/or Medicaid patients would also perpetuate a substantial cost-shifting problem.

3. Employment-based benefits. Employers who wish to continue offering health care benefits to their employees would be allowed to do so, in accordance with ERISA. If their employees also wanted to be eligible for CHAPCO benefits, which are likely to be more comprehensive, the employees would simply be asked to report the details of their benefits packages to CHAPCO, which would then calculate the dollar value of those benefits in terms of CHAPCO's fee schedule. This would be done both for the employer's contribution and the employee's contribution to the overall benefits package. The employee's obligation to the CHAPCO assessment would be reduced by the total adjusted value of the benefits package. How this would be done would depend on the method for financing CHAPCO that the General Assembly chooses (see Topic l-8, page 28). Those employees would be bound by the terms of the employer-sponsored benefits

package for whatever benefits were covered, but they would be free to use CHAPCO for all other health care needs covered by CHAPCO.

4. Private insurers. Private insurers could continue to underwrite employer-supported health care packages (such as those for federal employees and employees of multi-state corporations that choose to maintain their own benefits packages). Private insurers would also be free to offer coverage for services not covered by CHAPCO. Private insurance providers would not be allowed to offer policies that cover some or all of the co-payments for services covered by CHAPCO (Topic e-2, page 15), because this would reduce the cost-consciousness that the co-payment system is intended to foster. Private insurers should not be allowed to offer policies that compete with CHAPCO, because this would lead to proliferation of administrative expenses that would destroy one of the main benefits of a single-payer system.

(2) Who will benefit from this proposal? Who will be negatively affected by this proposal?

Everyone in the State of Colorado will benefit in at least two ways: (1) they will be covered for all basic health care needs and (2) there will be no connection between employment and health insurance. Employers will benefit because they will no longer need to offer health insurance as a fringe benefit for their employees (although they may choose to do so). As the overall health of the population improves, employers will benefit from reduced employee sick time. Providers will benefit by a large reduction in administrative duties, which will allow them to spend more time with patients.

Upper income residents will be negatively affected in the same way they are negatively affected by the federal and state income taxes—they will pay more than they are likely to receive in direct benefits. Some employees of health insurance firms, as well as some clerical staff in doctors' offices and hospitals will lose their jobs, although the proposed single-payer system (CHAPCO) will also generate new jobs. There is no reason why CHAPCO should not hire outside contractors to handle billing, processing of reimbursements to providers and preparation of statements to patients. The information technology needs could also be handled on a contract basis. A re-training program could

be offered to former private sector employees who have difficulty finding new employment.

(3) How will your proposal impact distinct populations (e.g. low-income, rural, immigrant, ethnic minority, disabled)?

The proposed system will offer health insurance to all residents of the State of Colorado, thereby removing a major financial burden and the threat of bankruptcy from medical expenses, to which all low-income segments of the population are constantly exposed. Rural areas will benefit from increased access to specialized facilities, either from subsidies to set up those facilities in underserved regions or by provision of transportation and housing for patients who need to go to an urban center for treatment.

(4) Please provide any evidence regarding the success or failure of your approach. Please attach.

Single-payer systems have not been tried in the United States, but they are in widespread use in other technologically advanced nations. Most national health care systems are considered successes by the majority of citizens in those countries, although problems do occur. Canada's notorious long waits for hospital care arose from politically-motivated reduced funding, which underscores the importance of making funding stable and insulating it from shifts in political philosophy by those in power.

***(*5) How will the program(s) included in the proposal be governed and administered?**

. I recommend that the Governor of Colorado should nominate two persons from each Congressional district to serve as members of the Governing Board, so that each member would represent equal populations. Those nominations should require confirmation by a majority vote of the Colorado Senate. It would be desirable for members of the Governing Board to be health care professionals or persons with

substantial expertise in health care policy and administration. Governors could serve for eight years, with one from each district being replaced or reappointed every four years.

The Governing Board should appoint a Chief Executive Officer (CEO) for CHAPCO. The appointment should require approval by at least nine of the 14 members of the Board. The CEO would have overall responsibility for appointing major subordinates and for carrying out the mandates of the Governing Board. It would also be desirable to have a Regional Director for each congressional district, with appropriate staff in an office located within that district.

(6) To the best of your knowledge, will any federal or state laws or regulations need to be changed to implement this proposal (e.g. federal Medicaid waiver, worker's compensation, auto insurance, ERISA)? If known, what changes will be necessary?

If Medicare and Medicaid patients are to be covered by CHAPCO, waivers that would allow payments from those federal agencies to be incorporated into CHAPCO will be necessary. However, the system could be established without including Medicare or Medicaid patients (not desirable, but possible).

The medical expense portion of workers' compensation would become unnecessary, so a change in the law defining workers' compensation requirements would be necessary. The law mandating auto insurance would not need to be changed, but insurers would probably choose to modify the policies they offer to Colorado residents.

The proposal has been crafted to avoid conflict with ERISA.

(7) How will your program be implemented? How will your proposal transition from the current system to the proposal program? Over what time period?

An important feature of this proposal is a transition period of two years during which staff will work out organizational details of the full program prior to its activation in July of 2010. A comprehensive health care plan should not be imposed on an entire

state by legislative fiat. A long and detailed planning period will be necessary. The first duties of the Governing Board, CEO and initial CHAPCO staff would be to organize the basic operational features of CHAPCO before the program is activated. Those problems include consultation with various groups who would be affected, among which are individual health care providers, hospitals, and employers who currently offer health care insurance to employees. Design of a record-keeping system should also precede activation of the program.

If the General Assembly authorizes transitional planning for CHAPCO during the 2008 session, then CHAPCO staff should be able to provide enough information by early 2009 for the General Assembly to draft a complete bill, with a detailed funding mechanism. Because new taxes would be required, the full CHAPCO proposal would presumably have to be submitted as a referendum to the voters in the fall of 2009. If approved, CHAPCO could be activated in July of 2010. Funding the transitional period should be done without a tax increase, to avoid the need for voter approval.

Topic (c) Access

(1) Does this proposal expand access? If so, please explain.

Yes, this proposal makes affordable access to basic health care available to all residents of Colorado.

(2) How will the program affect safety net providers?

Safety net providers will enter a period of unprecedented abundance because they will be paid the same rates as all other providers are paid. This increased income is likely to have several effects. First, cost-shifting by doctors and hospitals who serve the uninsured will no longer be necessary. This will reduce the fees they need to charge in order to cover their expenses for patients who cannot pay.

Safety net clinics may evolve into standard group practices, but other possibilities exist. They might, for example, use some of their new income to set up health education programs for their patients, with the goal of reducing the frequency of chronic diseases that often result from unhealthy life styles. In the long term, this could have an important effect on controlling costs for the entire state system.

Some need for safety net providers will remain, because there will be new residents who do not yet qualify for CHAPCO and some of them may be unable to buy private health insurance.

Topic (d) Coverage

(1) Does your proposal "expand health care coverage?" (Senate Bill 06-208) How?

The proposal expands health care coverage to include virtually all residents of Colorado.

(2) How will outreach and enrollment be conducted?

All residents of Colorado will be eligible to be enrolled in CHAPCO. An enrollment card should be sent to everyone who filed an income tax report the previous year. CHAPCO staff would have to devise some way for others to prove that they met the residency requirement. Possibilities include an affidavit from an employer or a Colorado driver's license that had been in effect for at least one year.

Outreach will be accomplished in several ways. The CHAPCO Department of Health Care Education will produce informative brochures, offer public lectures on health maintenance, and devise rewards for people who make significant improvement in some major aspect of their health. The CHAPCO Department of Patient and Provider Relations will make it possible for dissatisfied persons to discuss their problems with an ombudsman. Another form of outreach will be publication of the list of fees that providers may charge, along with explicit information on the periodic statements sent to each patient about the services that were provided.

(3) If applicable, how does your proposal define "resident?"

All persons who have been residents of the State of Colorado for at least one year prior to passage of legislation authorizing CHAPCO should be eligible for coverage by CHAPCO. Infants less than one year old whose parents are eligible for CHAPCO should also be covered. Rules for defining residency and for resolving ambiguous cases (such as

homeless persons and part-year residents) should be formulated and applied by the Governing Board. The thorny issue of whether to provide health care for illegal immigrants will also have to be decided. If they are employed it would be difficult to justify excluding them.

The possibility that activation of CHAPCO will lead to a massive influx of low-income people from other states seeking free or almost free health care will also have to be considered. It may be necessary to establish more stringent residency requirements (such as three years) for people who move into the state after some specific date. Those new residents would have to purchase private health insurance if they did not have employer-based insurance, or depend on safety net providers if they could not afford private insurance.

It would also be desirable for CHAPCO to offer a program analogous to the federal COBRA coverage, to help Colorado residents who move to other states. For example, CHAPCO could cover health care expenses for six months for Colorado emigrants who had already had CHAPCO coverage for at least one year. Reimbursements would be limited to CHAPCO rates and documentation of expenses would be the patient's responsibility. Additional documentation to minimize "double-dipping" during those six months would be necessary.

Topic (e) Affordability

(1) If applicable, what will enrollee and/or employer premium-sharing requirements be?

All residents of Colorado would be eligible to become enrollees in CHAPCO and would contribute to financing the program via one of the schemes described in Topic l-8 (page 28). Employers who wish to continue health benefits programs could do so.

(2) How will co-payments and other cost-sharing be structured?

In order to preserve some beneficial aspects of market forces in health care, the CHAPCO system should establish a limited form of co-payments. However, it is well

known that even a small co-payment will prevent many poor people from seeking health care, so the co-payment should only be required from patients with middle and upper incomes. For example, a 10% co-payment could be required from all patients whose Federal Adjusted Gross Income in the previous calendar year was $25,000 or more. Providers would not need to have information on patients' income status and would not collect co-payments. CHAPCO's finance department could handle this, using data supplied by the Colorado Department of Revenue and sending out bills to patients who owed co-payments. There should also be an upper limit on co-payments, because even 10% of the cost of catastrophic illness could be too much for middle-income people. I suggest limiting total co-payments in one year to 10% of adjusted gross income reported in the previous year.

If the co-payment system has the desired effect, it will stimulate cost-consciousness by patients. A simple system for reporting dissatisfaction (by email, ordinary mail, or directly to an ombudsman) should be designed. Then there is likely to be feedback like the following imaginary example. "My name is John Goodman. Last month Dr. Smith used a bleepostat to treat my skalids. His fee, which you paid, was $500. I think that is excessive. I am an engineer, familiar with the design of bleepostats. They are simple, rugged instruments, costing less than $5000 and requiring little maintenance. The treatment only took 10-15 minutes of Dr. Smith's time. I urge you to consider whether the customary fee for this procedure should be reduced."

Whether feedback produced by the co-payment system would be sufficiently helpful to outweigh some likely avoidance of health care because of the co-payments can only be determined by experience. The system should remain flexible.

Co-payments could also be used to encourage providers to compete with one another by offering some services at less than the CHAPCO-authorized rate. For example, a provider who is willing to accept 90% of the CHAPCO-authorized fee for a given service could excuse a patient from the entire co-payment.

In general, consumers of health care have much less market clout than consumers of other services. When you have a fever or a pain in your belly, you want to go to a doctor as soon as possible; you don't spend much time trying to find the lowest price provider. The problem of limited market power by patients also applies to two-tier

systems, such as the one in Britain, where patients who can afford higher fees can obtain appointments with some doctors more quickly. If the system we establish in Colorado leads to excessive waits for physician or hospital appointments, then the system is flawed and it should be fixed, rather than offering the wealthy an easy way to bypass the problem.

Except for a few minor luxuries like a private room in a hospital, there is only one logical basis for separating health care services into basic versus enhanced (more expensive) levels. That basis is *provider excellence*. Of course, some providers are more experienced and/or more expert than most of their peers. The problem is how to identify them and reward them appropriately. If providers were allowed to evaluate themselves, they would all decide they were above average (the Lake Wobegon effect). However, if a professional organization such as the Colorado Medical Society were to establish criteria for evaluating professional excellence and then name individuals who were in the top 10%, CHAPCO's Governing Board should consider allowing those providers to charge somewhat higher fees (which would be covered by CHAPCO).

Topic (f) Portability

(1) Please describe any provisions for assuring that individuals maintain access to coverage even as life circumstances (e.g. employment, public program eligibility) and health status change.

There would be complete portability. All residents of Colorado would have access to any licensed health care provider in Colorado at all times, regardless of employment or health status. Health care costs incurred anywhere else in the United States by a person covered by CHAPCO should be reimbursed at the CHAPCO rate to the insured person, who would have to be responsible for providing acceptable documentation of those costs. CHAPCO benefits should not be available outside of the United States.

Topic (g) Benefits

(1) Please describe how and why you believe the benefits under your proposal are adequate, have appropriate limitations and address distinct populations.

CHAPCO coverage would include outpatient care by primary providers and specialists, inpatient care in hospitals, emergency care, mental health services, basic vision and hearing care and correction, basic dental care, preventive health care, and prescription drugs. However, it will probably be necessary to exclude some health care services from coverage by CHAPCO, in order to achieve cost containment (discussed under Topic b-1, page 7). Those decisions should be left to the discretion of the Governing Board after consultation with appropriate experts.

One of the main reasons that health care costs rise continually is that new drugs and new instruments are becoming available at a rapid rate. There is no foreseeable limit to biomedical advances. Therefore, it will eventually be possible to spend more on health care for an average person than the average person's lifetime income! There always has been and always will be some form of health care rationing, with the wealthy able to obtain more extensive care than is available to the average person. This problem is becoming critical for end-of-life care, which is often extremely costly while accomplishing only a few months life extension.

Many nations with national health care systems have recognized this. For example, Britain, France and Germany each have expert committees who evaluate new drugs and procedures for inclusion under their systems. Britain recently rejected two new colon cancer drugs because their cost did not justify the few additional months of life they provided to an average patient. Medicare will soon face the necessity of refusing coverage for highly expensive but short-term life-extending procedures for patients beyond a given age. Every health care system, whether regional, national or private, will have to make such decisions with increasing frequency as technology advances. The problem is not yet acute here, nor is there any general formula for calculating what percent of GDP should be spent on health care, but planners should recognize that there must be limits. It will not be long before any system that tries to offer all possible medical care to every patient will be doomed to bankruptcy.

(2) Please identify an existing Colorado benefit package that is similar to the one(s) you are proposing (e.g. Small Group Standard Plan, Medicaid, etc) and describe any differences between the existing benefit package and your benefit package.

Medicare is the existing benefits plan that most closely resembles CHAPCO--the plan proposed here. CHAPCO would be more comprehensive, including basic dental, hearing and vision care.

Topic (h) Quality

(1) How will quality be defined, measured, and improved?

Quality will be defined and measured primarily in terms of patient and provider satisfaction. The Governing Board should establish a Department of Patient and Provider Relations within CHAPCO for the purpose of dealing with claims of inadequate or improper care by health care providers, claims of improper charges for services, and other types of dissatisfaction that may arise with patients. (This is also described under Topic b-1, page 5). Providers who feel that compensation for services covered by CHAPCO is inadequate would also submit their grievances to the ombudsmen. Ombudsmen should make formal reports to their regional directors on a quarterly basis; the regional directors would then make recommendations to the Governing Board if a change in CHAPCO's policies appeared to be needed.

(2) How, if at all, will quality of care be improved (e.g. using methods such as applying evidence to medicine, using information technology, improving provider training, aligning provider payment with outcomes, and improving cultural competency including ethnicity, sexual orientation, gender identity, education, and rural areas, etc.?)

In a very basic sense, overall quality of care will be improved because inability to pay will not lead to denial of care and no one will be restricted to a limited group of providers because of an employment-related benefits program. Development of a computerized database will also improve quality of care because providers will eventually have complete information on each patient at their fingertips and will be able to make more informed clinical decisions. The electronic database will also make outcomes analysis possible more easily and more thoroughly than at present. The educational programs suggested in other sections of this proposal should help patients with chronic disease become more involved in their own health maintenance, which is also an aspect of health care quality. I have also recommended ways to make specialized instrumentation more available to rural patients

Topic (i) Efficiency

(1) Does your proposal decrease or contain health care costs? How?

The proposal decreases overall health care costs in three ways: (a) a major reduction of administrative expenses by eliminating most private health insurance, (b) elimination of cost-shifting by covering everyone, regardless of income, and (c) bulk purchases of prescription drugs and durable medical equipment.

(2) To what extent does your proposal use incentives for providers, consumers, plans or others to reward behavior that minimizes costs and maximizes access and quality in the health care services? Please explain.

Several incentives are proposed. (i) A 10% co-payment should be required from all patients whose Federal Adjusted Gross Income in the previous calendar year was $25,000 or more. Being obliged to make co-payments should have some effect on patients' cost-consciousness, especially in regard to fees for outside procedures, where comparison shopping is more feasible than it is in regard to choosing a doctor. (ii) Co-payments could also be used to encourage providers to compete with one another by offering some services at less than the CHAPCO-authorized rate. For example, a

provider who is willing to accept 90% of the CHAPCO-authorized fee for a given service could excuse a patient from the entire co-payment. (iii) Financial rewards to persons who attend several educational sessions on preventive health care and then demonstrate an improvement in some quantifiable aspect of their health over a period of six months or longer. Possibilities might include a 20% reduction in weight for obese persons, a reduction of cholesterol level to some target, or giving up smoking (if some objective way of verifying that claim is available). The financial reward could be a reduction in co-payments for the next year or a cash payment to patients who are below the income level at which co-payments are required.

(3) Does this proposal address transparency of costs and quality? If so, please explain.

Yes, cost transparency is assured by requiring that the full list of CHAPCO-authorized fees must be available in every provider's office as well as in public libraries and on the CHAPCO web site. The proposal also recommends that every statement of services provided, which would be mailed periodically to patients just as Medicare does now, would contain a plain English identification of the procedures for which the provider requests reimbursement.

(4) How would your proposal impact administrative costs?

There would be a major reduction of administrative costs by eliminating the complex bookkeeping related to the current myriad of private health insurers. Woolhandler et al. [6] calculated that the United States spends 31% of total health care costs on administration. Their estimate includes administration and profits by private insurers, time spent by physicians on administration, clerical costs in physicians' offices, hospital administration and other sources. The comparable number for Canada, which has a single-payer system, was roughly 16%. Therefore it can be argued that conversion to a single-payer system here would save 31-16 = 15% of total health care costs. For

Colorado in 2004 terms, that would be a savings of $3.36 billion out of a total health care expenditure of $22.4 billion [3].

Topic (j) Consumer choice and empowerment

(1) Does your proposal address consumer choice? If so, how?

Health care consumers may go to any provider in the state.

(2) How, if at all, would your proposal help consumers to be more informed about and better equipped to engage in health care decisions?

The proposal recommends a Department of Public Health Education within CHAPCO, whose goals should be (1) to increase public awareness of CHAPCO benefits and exclusions, and (2) to increase public awareness of ways for individuals to lead healthy life styles and avoid illness.

Topic (k) Wellness and prevention

(1) How does your proposal address wellness and prevention?

The answer to question j-2 also applies here. Department of Public Health Education personnel should actively contact churches and social organizations, offering classes on preventive health care. This program should emphasize education in rural areas and in urban areas where low-income families tend to be concentrated. The proposal also recommends a program of financial incentives that would reward citizens for participating in preventive health care programs and improving their own health

Topic (l) Sustainability

(1) How is your proposal sustainable over the long-term?

The proposed program should be sustainable indefinitely, via the income tax and/or payroll tax suggested under Topic l-8, although it will be sensitive to recessions. . If possible, a surplus should be allowed to accumulate in CHAPCO Trust, to cushion the

effect of a recession. If a recession occurs, the basic funding mechanism (x% of taxable income and/or y % of payroll) should not be altered. I recommend that the CHAPCO Trust and the basic funding mechanism should be insulated from legislative poaching by an amendment to the Colorado constitution. If a recession occurs and income falters, the Governing Board could raise co-payments and reduce reimbursement rates. This would result in both providers and consumers sharing the consequences of the recession.

(2) (Optional) How much do you estimate this proposal will cost? How much do you estimate this proposal will save? Please explain.

There are actually two cost problems. First, if CHAPCO is initially set up as a transitional program as recommended (Topics b-1, page 3 and b-7, page 12), salaries and costs for the transitional staff will have to be paid. It would be very desirable to do this without imposing a new tax, in order to avoid the limitations of the TABOR amendment to the Colorado constitution. Perhaps this could be financed from the general fund or perhaps some non-state funds could be found. If the transitional staff consists of twenty people earning an average of $50,000 per year, one million dollars in salary would be needed plus money for supplies, office space, travel, etc. The transitional staff might have to be 40 or 50 people, so legislators should probably think in terms of finding at least three million dollars per year for the transitional years.

The larger problem is funding the full CHAPCO program. Financing CHAPCO would have to satisfy two major goals immediately: (A) replace private insurance payments for health care and (B) cover the health care expenses of those who were uninsured before CHAPCO was activated. If Medicare and Medicaid were incorporated into CHAPCO, there would be a third goal: (C) to bring reimbursements to providers under those two systems up to the level that CHAPCO would pay for all other insured persons.

Private insurance pays for 35% of all personal health care costs nationally [2]. Colorado spent a total of $22.4 billion on health care in 2004 (latest available) [3], and 35% of 22.4 is $7.84 billion.

The uninsured population of Colorado in 2004 was approximately 765,000 people [4]. Hadley and Holahan [5] calculated that an average uninsured person in the United

States spent $1587 on health care in 2001; I shall raise that number to $1800 for 2004. However, uninsured people spend as little as possible, so if they were covered by a system like CHAPCO, they would spend more. Hadley and Holahan offer a range of estimates and when I raise their maximum number for 2001 to a likely 2004 level, the number is $1900. Adding $1800 (previously uninsured people would no longer make out-of-pocket payments) and $1900 gives an estimated total spending of $3700 per person by previously uninsured people (in 2004 terms). Multiplying by 765,000 indicates that the previously uninsured would need $2.83 billion from CHAPCO.

The above numbers imply that CHAPCO would need to spend 7.84 + 2.83 = $10.67 billion in order to replace costs paid to private insurers and cover the uninsured. However, some reductions that would result from a single-payer system could be made. The largest reduction would come from the very high administrative expenses that are related to the current myriad of private insurers. Woolhandler and Himmelstein [6] calculated that the United States spends 31% of total health care costs on administration. Their estimate includes administration and profits by private insurers, time spent by physicians on administration, clerical costs in physicians' offices, hospital administration and other sources. The comparable number for Canada, which has a single-payer system, was roughly 16%. Therefore it can be argued that conversion to a single-payer system here would save 31-16 = 15% of total health care costs. For Colorado in 2004 terms, that would be a savings of $3.36 billion (22.4 x 0.15). (This assumes that providers would be willing to lower their fees in proportion to the reduction of costs made possible by CHAPCO.)

Another source of savings would come from the elimination of uncompensated care (care delivered to persons who cannot or do not pay). That is, hospitals and private providers would no longer have to engage in cost-shifting—increasing their charges to insured patients in order to cover losses from uncompensated care. Estimating the amount of savings from that source is complicated and quite uncertain, because there are many public programs that cover a large fraction of uncompensated care costs. I am going to use $0.4 billion—a very rough estimate based on data in [7]. (Here again, the savings cannot be realized unless providers lower their fees in proportion to the reduction of expenses made possible by CHAPCO).

A third source of savings would be bulk purchases of prescription drugs. Anderson et al. [8] give comparative data on pharmaceutical expenses for OECD countries in the year 2000. Extrapolating their numbers, I estimate that Canada spent $459 per capita in 2004 and the United States spent $662. The difference--$203 per capita—would produce savings of $913 million. There should also be significant savings from bulk purchases of durable medical goods. I shall use a round number of $1 billion savings (in 2004 terms) from all bulk purchases, which should be achievable under CHAPCO.

Adding $3.36 billion, $0.4, and $1.0 billion gives $4.76 that could be saved from reduction of administrative expenses, from elimination of cost-shifting related to uncompensated care, and from bulk purchases. There are no other major sources of potential savings that could be tapped immediately, so when we subtract $4.76 billion from $10.67 billion, we are left with $5.91 billion that would have to be raised by CHAPCO to cover the previously uninsured and people who previously used private health care insurers.

The co-payments suggested earlier in this proposal (Topics e-2, page 15 and i-2, page 20) would provide some of that $5.91 billion. In 2004, 33.6% of Colorado income tax returns fell into the $25,000-or-less category for federal adjusted gross income [9]. Thus, $3.92 billion (66.4% of 5.91) would be spent by the upper income two-thirds of patients (assuming that they incurred costs per capita roughly equal to those incurred by lower income patients). Their 10% co-payments would generate $0.39 billion, which reduces the funds that have to be raised from other sources to $5.52 billion.

However, CHAPCO would be a much more satisfactory system if Medicare and Medicaid patients were included. In 2004, Medicare spent $3.31 billion in Colorado [10], but Medicare only pays 80% of the authorized reimbursement amount, so another $0.83 billion would have been spent by Medicare patients out-of-pocket or via secondary insurance policies. Moreover, Medicare fees are widely claimed by providers to be too low (although that problem will diminish or even disappear when the heavy administrative expenses brewed in the witch's cauldron of private health insurance disappear.) I will arbitrarily add 10% to the above Medicare costs to cover an increase in

reimbursement fees ($0.41 billion). We now have $0.83 + $.41 = $1.24 billion needed to bring Medicare reimbursements up to the presumed CHAPCO level.

Medicaid expenses in Colorado in 2004 were $2.49 billion [10]. It is often claimed that Medicaid reimbursements are even lower than Medicare reimbursements, although general comparisons are hard to find. I shall make the assumption that raising Medicaid reimbursements to 125% of current payments would be sufficient to compensate providers fairly. In 2004 terms that would be $0.62 billion.

We must also remember that CHAPCO is intended to be a program for the *advancement* of health care, not just payment for health care. In the long run, teaching the public to avoid unhealthful activities and helping them achieve a better lifestyle, combined with preventive medicine, will save an enormous amount of money, but at first it will cost more than it saves. Education is cheaper than therapy, but I will add 5% to the above total (5.52+1.24+0.62=7.38) to fund CHAPCO's work in that area, which adds $0.37 billion.

In conclusion, full financing of CHAPCO is estimated to cost 5.52 + 1.24 + 0.62 +0.37 = $7.75 billion in 2004 terms. This includes a credit of $0.39 billion that would be generated by co-payments.

(3) Who will pay for any new costs under your proposal?

People would pay for the new system via Colorado income tax and/or payroll deductions. However, there would not really be any *net new costs* at the state level; the proposed income tax and/or payroll tax would be a *transfer* of expenses, currently paid by consumers and employers to insurance companies or directly to providers, into the CHAPCO Trust. Because of savings from reduction of administrative expenses, elimination of cost-shifting, and bulk purchases, the net result would be a substantial reduction in terms of overall state healthcare expenditures.

(4) How will distribution of costs for individuals, employees, employers, government, or others be affected by this proposal? Will each experience increased or decreased costs? Please explain.

Most Colorado residents, whether employed or not, would pay for the CHAPCO system via an assessment on Colorado taxable income or a payroll deduction (or both).

Employers would not be taxed, although those who voluntarily retain employee healthcare benefit plans would be allowed to do so. The program would be self-supporting; that is, no General Fund withdrawals would be needed. The federal government would continue to support Medicare and Medicaid programs.

(5) Are there new mandates that put specific requirements on payers in your proposal? Are any existing mandates on payers eliminated under your proposal? Please explain.

CHAPCO would become the primary health care payer. Some consumers would be required to make co-payments. Employees of businesses that chose to continue offering healthcare benefits to employees would be required to report the value of those benefits to CHAPCO, if they wanted to be excused from some or all of the assessment for funding CHAPCO. The medical portion of the workers' compensation mandate on employers could be eliminated.

(6) (Optional) How will your proposal impact cost-shifting? Please explain.

Cost-shifting would be eliminated, because all Colorado residents would be covered. Providers would be reimbursed for services to all patients.

Although cost-shifting takes place throughout the health care system, it is most conspicuous in hospitals, where the burden of uncompensated costs is particularly high. The federal requirement that emergency rooms treat everyone, regardless of ability to pay, is a major contributor to uncompensated care costs in hospitals, although other sources are also important. The current deplorable and unfair practice at most hospitals is to set a very high theoretical fee for most of their services, then accept much smaller payments (sometimes as little as 25% of the amount billed) from insurers but not from uninsured patients. This practice penalizes people for being uninsured and forces many to declare bankruptcy. Whether it really has a significant effect on hospitals' bottom line is the subject of heated debate.

That problem would no longer exist under CHAPCO, because there would be no uninsured patients. Presumably, CHAPCO fees for hospital services would be set at

approximately the average level now paid by private insurers, adjusted for reduction of administrative expenses and elimination of cost-shifting, which should allow most for-profit hospitals to remain in business. However, it is possible that some hospitals may decide to close, if corporate directors feel that they cannot make enough profit under CHAPCO. Ideally, for-profit hospitals should be transferred to community ownership and operated as not-for-profit institutions. Most cities should be able to accomplish purchase of a hospital by issuing municipal bonds, but if they cannot, CHAPCO and/or the General Assembly should have some plan ready to provide loans to nonprofit groups who wish to buy hospitals that are for sale. Closure of hospitals in communities where there is not a surplus of hospitals must not become a consequence of establishing a single-payer health care system.

(7) Are new public funds required for your proposal?

Yes, financing CHAPCO will require new public funds. See next section.

(8) (Optional) If your proposal requires new public funds, what will be the source of these new funds?

I shall outline two possibilities for funding CHAPCO. First, the required $7.75 billion (calculated in Topic l-2, pages 23-26) could be raised by a 7.53% tax on federal adjusted gross income (Numbers for 2004 are not available. I have raised the $99.9 billion reported in 2003 by 3% to estimate $103 billion for 2004; 0.0753 x 103 = 7.75) or by an 11.8% tax on Colorado taxable income (which I estimate was about $65.4 billion in 2004; 65.4 x 0.118 = 7.75). The 11.8% tax would be separate from and in addition to the existing 4.7% tax for general state purposes. Basing the tax on Colorado taxable income would have less impact on low-income taxpayers (many of whom would be required to pay very little or nothing if the Colorado taxable income assessment were adopted) and would allow retirees to benefit from the $24,000 pension and annuity subtraction.

However, a strong argument can be made that even people who earn the minimum wage should contribute something to CHAPCO, so an alternative way to fund CHAPCO would be a payroll tax. Total wage income reported to the Department of Revenue was

$72.96 billion in 2003, which I shall also raise by 3% to estimate the 2004 wage income as $75.15 billion (2004 numbers not available). These numbers imply that the $7.75 billion needed for CHAPCO could be raised by a payroll tax of 10.3%. Whether the payroll tax should be shared between the employer and the employee or imposed entirely on the employee is for legislators to decide. Of course, the General Assembly could choose a middle course, obtaining half of CHAPCO's funds from a payroll tax and half from an assessment on Colorado taxable income.

Another potential source of funds is the sales tax, but the state tax raised only $1.77 billion in 2004, so doubling the state sales tax would raise less than 25% of the overall funding needs of CHAPCO. Doubling "sin taxes" would not accomplish much: in 2004, the tobacco tax raised roughly $11.7 million, the cigarette tax raised $53.5 million, and the alcoholic beverage tax raised $31.3 million. In terms of CHAPCO's financing needs, those are trivial numbers. (All of those numbers would have to be adjusted for the factors applicable at the time CHAPCO is activated.)

As a matter of principle, it would be desirable to sever completely the relationship between employment and health care, which is widely recognized as a historical artifact. However, a large fraction (about 60%) of the labor force does receive health care benefits from employers, and the activation of CHAPCO could offer windfall profits to those employers by letting them drop health insurance precipitously and transfer the entire burden immediately to employees. Ideally, employers would offer raises to their employees to compensate for the value of the health insurance that they cancel, but ethical behavior cannot be legislated. Perhaps the General Assembly could devise some sort of reward, such as a tax credit, to encourage employers who decide to drop health insurance to give appropriate raises to their employees. Alternatively, a financial disincentive to drop health care benefits without a compensating wage increase might be devised.

Some Colorado citizens obtain most or all of their taxable income from non-wage sources. In drafting legislation, the General Assembly might like to set an upper limit on how much one taxpayer should be assessed for CHAPCO, but the limit would have to be high. It is essential for upper income people to pay more than they are likely to receive in

health care benefits for themselves, because it is not otherwise possible to fund universal coverage.

If the General Assembly decides to design legislation to create CHAPCO or any other single-payer system of health care, there will be a need for a massive educational effort before the legislation is referred to the voters. Financing the system described here would at first seem to many people to be an unbearable financial strain. The word "tax" implies increased spending to almost everyone, although the truth in this case is that the tax simply substitutes one form of spending for another. This tax might better be called a Health Care Savings Assessment. For lower income groups CHAPCO would offer health care that they mostly do without now and there would also be freedom from the threat of bankruptcy posed by health emergencies. For most middle-income Coloradans CHAPCO would actually reduce overall health care expenditures. For example, a person whose salary was $40,000 would pay $4120 to CHAPCO if the 10.3% payroll tax were used. That amount is less than individual coverage via most private health insurance plans costs now and much less than family coverage costs. It would be a great bargain! Only high-income Coloradans would pay more than they pay now, but that is a necessary feature of a civilized society.

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3. A single page describing how your proposal is either comprehensive or would fit into a comprehensive proposal

This proposal is comprehensive in several ways related to health care: it will offer coverage for virtually all medical needs to all residents of Colorado; pre-existing conditions will not be excluded; free choice of providers will be available to all patients; and there will be no mandated connection between employment and health insurance.

The proposal is comprehensive in another sense: it goes far beyond paying bills for health insurance. The proposal recommends a program of public education that should reduce the frequency and/or severity of chronic disease. Training of various types of health care professionals who are in short supply is recommended. A program for cost containment and transparency is outlined. Development of an electronic database that will facilitate clinical evaluations on an individual basis and will strengthen outcomes analysis on a population basis is also included in the proposal. In summary, the proposal offers a comprehensive program for advancing the organization, monitoring and delivery of health care to all Coloradans.

4. (Optional). A single page describing how your proposal was developed.

I gradually became interested in health care reform during the past several years as a result of reading many articles about the inadequacies of the current system in the newspaper and talking with friends who are uninsured. About two years ago I began attending meetings of Health Care for All Colorado, a single-payer advocacy group. Those meetings stimulated my thinking and persuaded me that major reform of our health care system at the state level was feasible and essential. When I learned about the SB208 Commission, I decided to write my own health care reform proposal. I am a retired (but active) Professor Emeritus of Molecular Biology at the University of Colorado in Boulder. My professional expertise is not directly related to health care policy, but my experience in organizing and explaining complicated information, either for publication or for grant applications, is definitely relevant. My orientation toward a quantitative approach will be obvious throughout the proposal.

In my opinion, a piecemeal or "band-aid" approach to the inefficiency and unfairness of our current health care system cannot produce a major improvement. The system must be transformed, both in terms of providing coverage for illness and in terms of reducing avoidable illness through consumer education. Here in Colorado, with our relatively small but educated population, we have the possibility of building on our sense of community to create a system that could be a model for the entire country. I hope the SB208 Commission will recommend some type of bold reform to the General Assembly and that at least several legislators will become diligent and vocal advocates for comprehensive reform of our health care system. Then it will be up to the voters.